Virtual Mentor
American Medical Association Journal of Ethics
June 2007, Volume 9, Number 6: 437-440.

Health law
Effects of malpractice law on the practice of medicine
by Lee Black, LLM

The medical and legal professions have similar goals. For each, the interests of the patient and client are of paramount importance—the professions' respective ethical codes require this. When the patient of a physician becomes the client of an attorney, however, medicine's goal of providing appropriate and safe care may get distorted.

The premise of a medical malpractice action is "a doctor's failure to exercise the degree of care and skill that a physician and surgeon of the same medical specialty would use under similar circumstances" [1]. This area of law, where an individual is compensated for a harm caused by another, has long provided the means to ensure a just outcome, where otherwise there would be none. Yet the modern medical malpractice system appears fraught with injustice, and that perception negatively affects how physicians view and care for patients.

It is frequently argued that, because injured patients are able to obtain large jury awards, medical malpractice causes insurance rates to rise and access to care to decline [2]. Others dispute this claim and instead point to different factors as causing the crisis in medicine [3]. Regardless, the mere perception of injustice and the danger of liability have fueled physician paranoia and distracted physicians from the goal of providing the best and safest care to patients.

Defensive medicine
Paranoia is a strong word but accurate in the sense that physicians often take actions that may not be necessary yet, because of the fear of liability, appear justified to avoid lawsuits. This practice is known as defensive medicine. The defensive practice of medicine is the "deviation from sound medical practice that is induced primarily by a threat of liability" [4] and it includes supplemental care, such as additional testing or treatment; replaced care, such as referral to other physicians; and reduced care, including refusal to treat particular patients [4].

The goal of defensive medicine is to ensure that, if the patient later sues, the physician has gone above and beyond what is required. Defensive medicine is directly traced to medical malpractice law—without the threat of litigation, there would be no reason to practice defensively.

To many, supplemental care is not a bad thing. Why not do everything possible for patients? One reason is the fiscal consequences. Some believe that it is a primary

factor in the high rate of increase of health care spending; others acknowledge the impact but discount its overall effects [5]. Cost aside, the physical and psychological consequences should be of real concern. Diagnostic tests and invasive procedures increase the risk of psychological harm, with the possibility of false positives and ensuing anxiety. Unnecessary invasive procedures increase the risk of physical injury to patients (and therefore can ultimately increase the risk of liability).

No physician wants to be sued on the premise that he or she did not do enough. Yet, the medical profession sets its own standards of care, as the definition of medical malpractice noted above specifies. If other physicians using appropriate judgment and skill would not run a test or use a procedure in a given situation, it need not be done. In many instances, patients themselves request something that is not medically indicated. Physicians should not comply with the request just because a patient asked and the physician fears future liability.

Unfortunately, because physicians set the standard of care, defensive medicine can create new standards. If enough physicians react a certain way to a particular diagnosis, that reaction could very well become the standard [4]. In effect, bad medical practice could become the standard, and what used to be the standard (i.e., a practice formerly considered good medicine on the basis of scientific evidence, not paranoia) could then become a basis for liability.

State recognition of defensive medicine

A study by Studdert et al. [4] notes the difficulty in measuring the true extent of defensive medicine but also provides good evidence that the practice is, to some extent, really happening. Limited knowledge has not stopped legislatures from using concerns about defensive medicine as a basis for tort reform legislation. Utah's legislature states that "the effect of increased insurance premiums and insurance claims is increased health care cost…through the provider's practicing defensive medicine because he views a patient as a potential adversary in a lawsuit" [6]. The legislature of Wisconsin similarly found that "the rising number of suits and claims is forcing both individual and institutional health care providers to practice defensively, to the detriment of the health care provider and the patient" [7].

Questions have been raised as to the accuracy of defensive medicine claims by legislatures. The Wisconsin Supreme Court argued that it is "virtually impossible" to measure defensive medicine accurately, the same conclusion reached by Studdart et al. While there is much anecdotal support in favor of the widespread practice of defensive medicine, governmental agencies have found that this does not contribute significantly to the cost of health care [8]. For this reason, the Wisconsin Supreme Court determined that defensive medicine should not be a factor for damage caps.

A distorted goal of medicine

The debate over the extent and cost of its occurrence notwithstanding, there is enough anecdotal evidence that defensive medicine is being practiced [9]. Some physicians say that they will not treat a patient who is perceived to be litigious, or is

a medical malpractice attorney (or is related to an attorney). There have even been incidents of blacklisting patients who have filed claims in the past [10]. Other physicians say that they provide additional tests or recommend procedures that, while not necessary, could protect them in event of a lawsuit. This is not the way medicine should be practiced, and doing so risks further damaging the patient-physician relationship, as well as access to quality care.

The specific effects of defensive medicine are claimed to include additional and unnecessary care, referral to other physicians and refusing to serve certain patients or patient populations. Certainly, physicians who reduce their practices or leave litigious regions of the country have been major drivers of the American Medical Association's tort reform efforts, primarily because of the recognition that these actions can have severely detrimental consequences for patient populations.

Yet all of these effects stem from a system of law meant to ensure that the injured are properly compensated—an important societal goal. The medical malpractice system can also promote quality care by properly punishing those who fail to provide it. Indeed, quality and access have long been concerns of the legal system. The Emergency Medical Treatment and Active Labor Act (EMTALA) and current efforts to encourage quality care through payment incentives are legislative means for encouraging physicians to meet the goals of medicine.

Defensive medicine, though, is an aberration of both the law and the practice of medicine. Exaggerated or not, publicity surrounding large, but rare, jury verdicts and other horror stories of medical malpractice have led to the perception that the legal system is hostile to physicians and the practice of medicine. In response, some physicians have begun to act in their own best financial interests, rather than the interests of the health and well-being of their patients. This is not to say that patients are no longer the primary concern of physicians, but another factor has entered the equation and, in many ways, corrupted physicians' dedication to patient-centered goals.

Notes and references

1. Garner BA, ed. *Black's Law Dictionary*. 7th ed. St. Paul, MN: West Group; 1999.
2. American Medical Association. Medical Liability Reform—Now! http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnow.pdf. Accessed May 3, 2007.
3. See generally Rapp GC. Doctors, duties, death and data: A critical review of the empirical literature on medical malpractice and tort reform. *N Ill U L Rev*. 2006;26:439-468.
4. Studdert DM, Mello MM, Sage WM, et al. Defensive medicine among high risk specialist physicians in a volatile malpractice environment. *JAMA*. 2005;293(21):2609-2617.
5. *Ferdon v Wisconsin Patients Compensation Fund*, 701 NW2d 440, 463 (Wis. 2005):487-489.

6. Utah Code Annotated, sec 78-14-2 (2006). http://le.utah.gov/~code/TITLE78/htm/78_13003.htm. Accessed May 11, 2007.
7. *Ferdon v Wisconsin Patients Compensation Fund*.
8. *Ferdon v Wisconsin Patients Compensation Fund*, 488.
9. See generally Sage WM. Regulating for patient safety: the law's response to medical errors: malpractice reform as a health policy problem. *Widener L Rev.* 2005;12:107-119.
10. Blumenthal B. In Texas, hire a lawyer, forget about a doctor? *New York Times.* March 5, 2004:A12.

Lee Black, LLM, is a senior research associate for the Council on Ethical and Judicial Affairs at the American Medical Association in Chicago. Prior to joining the AMA, he was a staff attorney with the Legislative Reference Bureau in Springfield, where he drafted legislation for the Illinois General Assembly.